WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
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HERNIA SURGERY REFERRAL FORM

REFERRAL DATE: ____/____/______
DD / MM / YYYY

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

MRN:____________ HCN:______________________

Name:______________________________________

Sex:__________ Date of Birth:_____/_____/_____
DD / MM / YYYY

Address:____________________________________

Telephone:______________ Alternate #:___________

ADDITIONAL PATIENT INFORMATION

Preferred name: Gender (*if not same as above*):

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ ________________

Other insurance coverage (IFH, UHIP, etc.): ☐ Self-pay

Language spoken: Interpreter required: ☐ Yes ☐ No

REFERRING PROVIDER INFORMATION

Name:	Billing #: ______________
Address:	Signature: ______________
Telephone:	
Fax:	

❑ Referring Provider is not the Primary Care Provider
Primary Care Provider Name: ________________________________
Primary Care Provider Telephone: ________________________________

REASON FOR REFERRAL

☐ Inguinal hernia:____

☐ Umbilical hernia:____

☐ Epigastric hernia (above umbilicus):____________________________

☐ Other hernia:____

ADDITIONAL CLINICAL INFORMATION

Has the patient had hernia surgery before?
☐ No ☐ Yes: ____

Is the patient taking anticoagulants
☐ No ☐ Yes: ____

Height and weight:____

ADDITIONAL CLINICAL INFORMATION

Past medical/surgical history: ***(diagnostic imaging is not necessary)***

Allergies and reaction:

Current medications (include list):

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